Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ORTHOPAEDIC ASSOCIATES OF CENTRAL
TEXAS
108 WINCHESTER BLVD
DRIPPING SPIRNGS TX 78620

Respondent Name
TRUCK INSURANCE EXCHANGE

Carrier's Austin Representative Box
Box Number 14

MFDR Tracking Number
M4-13-2180-01

MFDR Date Received
APRIL 30, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the request for medical fee dispute resolution.

Amount in Dispute: $1,716.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or it's agent did not submit a response to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 18, 2012	CPT Code 26055-F2 CPT Code 26055-59-F3	$1,716.00	$837.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 29 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional services.

7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment adjusted for absence of precent/preauth.
   - 29 – The time limit for filing claim/bill has expired.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided..." Review of the documentation submitted by the requestor finds that a copy of a transmission log dated June 6, 2012 with a status of OK, showing that the requestor submitted the bill to the insurance carrier within the timeframes.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has not forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.
3. The respondent also denied the services using denial code "197 – Payment adjusted for absence of precert/preauth." Review of the documentation submitted by the requestor finds that preauthorization was approved by CorVel on May 4, 2012; CorVel preauthorization number is 71067239-1. Therefore the denial reason is not supported and the disputed date of service will be reviewed in accordance with 28 Texas Administrative Code §134.203.

   In accordance with 28 Texas Administrative Code §134.203(c)(1) the professional services for surgeries performed at an ASC and provided by Orthopaedic Associates of Central Texas for date of service May 18, 2012 are as follows:

   - CPT Code 26055-F2, 1 Unit – (68.88 ÷ 34.0376) x $295.61 = $498.21
   - CPT Code 26055-59-F3, 1 Unit – 59 Modifier is supported as the operative report documents a second incision was made over the left 4th digit overlying the MP joint. (68.88 ÷ 34.0376) x 295.61 ÷ 2 (multiple procedure rule applies) = $299.11

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $837.32.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $837.32 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 23, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.